645—43.10(151) Record keeping.

43.10(1) Chiropractic physicians shall maintain clinical records in a manner consistent with the protection of the welfare of the patient. Records shall be timely, dated, chronological, accurate, signed or initialed, legible, and easily understandable. Record-keeping rules apply to all patient records whether handwritten, typed or maintained electronically. Electronic signatures are acceptable when the record has been reviewed by the physician whose signature appears on the record.

43.10(2) Chiropractic physicians shall maintain clinical records for each patient. The clinical records shall, at a minimum, include all of the following:

a. Personal data.

(1) Name;

(2) Date of birth;

(3) Address; and

(4) Name of parent or guardian if a patient is a minor.

b. Health history. Records shall include information from the patient or the patient's parent or guardian regarding the patient's health history.

c. Patient's reason for visit. When a patient presents with a chief complaint, clinical records shall include the patient's stated health concerns.

d. Clinical examination progress notes. Records shall include chronological dates and descriptions of the following:

(1) Clinical examination findings, tests conducted, a summary of all pertinent diagnoses, and updated health assessments;

(2) Plan of intended treatment, including description of treatment, frequency and duration;

(3) Services rendered and any treatment complications;

(4) All testing ordered or performed;

(5) Diagnostic imaging report if imaging procedure is ordered or performed;

(6) Sufficient data to support the recommended treatment plan.

e. Clinical record. Each page of the clinical record shall include the patient's name, the date information was recorded and the doctor's name or facility's name.

43.10(3) Retention of records. A chiropractic physician shall maintain a patient's record(s) for a minimum of six years after the date of last examination or treatment. Records for minors shall be maintained for one year after the patient reaches the age of majority (18) or six years after the date of last examination or treatment, whichever is longer. Proper safeguards shall be maintained to ensure the safety of records from destructive elements. This provision includes both clinical and fiscal records.

43.10(4) Electronic record keeping. When electronic records, which include both electronically created records and scanned paper records, are utilized, a chiropractic physician shall maintain either a duplicate hard-copy record or a backup electronic record.

43.10(5) Correction of written records. Notations shall be legible, written in ink, and contain no erasures or whiteouts. If incorrect information is placed in the record, it must be crossed out with a single nondeleting line. Entries recorded at a time other than the date of the patient encounter must include the date of the entry and the initials of the author.

43.10(6) Correction of electronic records. Any alterations made after the date of service shall be visibly recorded. All alterations shall include a notation setting forth the date of alteration and identification of the author. Entries recorded at a time other than the date of the patient encounter must include the date of the entry and the initials of the author.

43.10(7) Abbreviations shall be standard and common to all health care disciplines. Nonstandard abbreviations shall be referenced with a key that is included in the record when the record is requested.

43.10(8) Confidentiality and transfer of records. Chiropractic physicians shall preserve the confidentiality of patient records. Upon signed request of the patient, the chiropractic physician shall furnish such records or copies of the records as directed by the patient within 30 days. A notation indicating the items transferred, date of transfer and method of transfer shall be maintained in the patient record. The chiropractic physician may charge a reasonable fee for duplication of records but may not refuse to transfer records for nonpayment of any fees. A written request may be required before

the transfer of the record(s), including, for example, compliance with HIPAA regulations. In certain instances, a summary of the record may be more beneficial for the future treatment of the patient; however, if a third party requests copies of the original documentation, that request must be honored.

43.10(9) Retirement or discontinuance of practice. A licensee, upon retirement, discontinuation of the practice of chiropractic, leaving a practice, or moving from a community, shall:

a. Notify all active patients, in writing and by publication, once a week for three consecutive weeks in a newspaper of general circulation in the community. The notification shall include the following information:

(1) That the licensee intends to discontinue the practice of chiropractic in the community and that patients are encouraged to seek the services of another licensee; and

(2) How patients can obtain their records, including the name and contact information of the records custodian.

b. Make reasonable arrangements with active patients for the transfer of patient records, or copies of those records, to the succeeding licensee.

c. For the purposes of this subrule, "active patient" means a person whom the licensee has examined, treated, cared for, or otherwise consulted with during the one-year period prior to retirement, discontinuation of the practice of chiropractic, leaving a practice, or moving from a community.

43.10(10) Record-keeping procedures and standards shall be utilized for all individuals who receive treatment from a chiropractic physician in all sites where care is provided.

43.10(11) A chiropractic physician who offers a prepayment plan for chiropractic services shall:

a. Have a written prepayment policy statement that is maintained in the office and available to patients upon request. The policy statement, at a minimum, shall include provisions that:

(1) Prepaid funds will not be expended until services are provided; and

(2) The patient shall receive a prompt refund of any unused funds upon request. The refund shall be calculated based on a defined method, which shall be clearly set forth in the written prepayment policy statement.

b. Require the patient to sign and date a prepayment document that incorporates the conditions and descriptions of the written prepayment policy statement.

c. Maintain the signed and dated written prepayment policy statement in the patient's record.

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